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106TH CONGRESS
2D SESSION

S. 2237

To amend the Internal Revenue Code of 1986 to provide for the deductibility of premiums for any medigap insurance policy or Medicare+Choice plan which contains an outpatient prescription drug benefit, and to amend title XVIII of the Social Security Act to provide authority to expand existing medigap insurance policies.

IN THE SENATE OF THE UNITED STATES

MARCH 9, 2000

Mr. CRAIG introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Internal Revenue Code of 1986 to provide for the deductibility of premiums for any medigap insurance policy or Medicare+Choice plan which contains an outpatient prescription drug benefit, and to amend title XVIII of the Social Security Act to provide authority to expand existing medigap insurance policies.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Seniors’ Security Act of 2000”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Deduction for premiums for medigap insurance policies and Medicare+Choice plans containing outpatient prescription drug benefits and for long-term care insurance.

Sec. 3. Determination of annual actuarial value of drug benefits covered under a Medicare+Choice plan and a medigap policy.

Sec. 4. Inclusion of qualified long-term care insurance contracts in cafeteria plans and flexible spending arrangements.

Sec. 5. Authority to provide for additional medigap insurance policies.

SEC. 2. DEDUCTION FOR PREMIUMS FOR MEDIGAP INSURANCE POLICIES AND MEDICARE+CHOICE PLANS CONTAINING OUTPATIENT PRESCRIPTION DRUG BENEFITS AND FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

“SEC. 222. PREMIUMS FOR MEDIGAP INSURANCE POLICIES AND MEDICARE+CHOICE PLANS CONTAINING OUTPATIENT PRESCRIPTION DRUG BENEFITS AND FOR LONG-TERM CARE INSURANCE.

“(a) DEDUCTION.—

“(1) IN GENERAL.—There shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for—

“(A) any medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act) which contains an outpatient prescription drug benefit with an annual actuarial value that is equal to or greater than \$500,

“(B) any Medicare+Choice plan (as defined in section 1859(b)(1) of such Act) which contains an outpatient prescription drug benefit with an annual actuarial value that is equal to or greater than \$500, and

“(C) any coverage limited to qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)).

“(2) INFLATION ADJUSTMENT.—

“(A) IN GENERAL.—In the case of any calendar year beginning after 2000, each of the dollar amounts in subparagraphs (A) and (B) of paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount, multiplied by

“(ii) an adjustment for changes in per capita expenditures under title XVIII of the Social Security Act for prescription

1 drugs as determined under the most recent
2 Health Care Financing Administration Na-
3 tional Health Expenditure projection.

4 “(B) ROUNDING.—If any dollar amount
5 after being increased under subparagraph (A) is
6 not a multiple of \$10, such dollar amount shall
7 be rounded to the nearest multiple of \$10.

8 “(b) LIMITATIONS.—

9 “(1) DEDUCTION NOT AVAILABLE TO INDIVID-
10 UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-
11 ERAGE.—

12 “(A) IN GENERAL.—In any taxable year—

13 “(i) subsection (a) shall not apply
14 with respect to any policy or coverage de-
15 scribed in paragraph (1)(A) or (1)(B) of
16 such subsection if in such taxable year the
17 taxpayer is eligible to participate in any
18 employer-subsidized plan for individuals
19 age 65 or older which contains an out-
20 patient prescription drug benefit described
21 in such subsection, and

22 “(ii) subsection (a) shall not apply
23 with respect to any policy or coverage de-
24 scribed in paragraph (1)(C) of such sub-
25 section if in such taxable year the taxpayer

1 is eligible to participate in any employer-
2 subsidized plan which includes coverage for
3 qualified long-term care services (as so de-
4 fined) or any qualified long-term care in-
5 surance contract (as so defined).

6 “(B) EMPLOYER-SUBSIDIZED PLAN.—For
7 purposes of subparagraph (A)—

8 “(i) IN GENERAL.—The term ‘em-
9 ployer-subsidized plan’ means any plan de-
10 scribed in subparagraph (A)—

11 “(I) which is maintained by any
12 employer (or former employer) of the
13 taxpayer or of the spouse of the tax-
14 payer, and

15 “(II) 50 percent or more of the
16 cost of the premium of which (deter-
17 mined under section 4980B) is paid
18 or incurred by the employer.

19 “(ii) EMPLOYER CONTRIBUTIONS TO
20 CAFETERIA PLANS, FLEXIBLE SPENDING
21 ARRANGEMENTS, AND MEDICAL SAVINGS
22 ACCOUNTS.—Employer contributions to a
23 cafeteria plan, a flexible spending or simi-
24 lar arrangement, or a medical savings ac-
25 count which are excluded from gross in-

1 come under section 106 shall be treated for
2 purposes of this subparagraph as paid by
3 the employer.

4 “(C) AGGREGATION OF PLANS OF EM-
5 PLOYER.—A health plan which is not otherwise
6 described in subparagraph (A) shall be treated
7 as described in such subparagraph if such plan
8 would be so described if all health plans of per-
9 sons treated as a single employer under sub-
10 section (b), (c), (m), or (o) of section 414 were
11 treated as one health plan.

12 “(D) SEPARATE APPLICATION TO HEALTH
13 INSURANCE AND LONG-TERM CARE INSUR-
14 ANCE.—Subparagraphs (A) and (C) shall be
15 applied separately with respect to—

16 “(i) plans which include coverage lim-
17 ited to qualified long-term care services or
18 are qualified long-term care insurance con-
19 tracts, and

20 “(ii) plans which do not include such
21 coverage and are not such contracts.

22 “(E) DEDUCTION AVAILABLE WITH RE-
23 SPECT TO POLICIES AND PLANS CONTAINING
24 OUTPATIENT PRESCRIPTION DRUG COVERAGE IF
25 DISCLOSURE REQUIREMENTS ARE MET.—Sub-

section (a) shall apply in any taxable year with respect to any policy or plan described in paragraph (1)(A) or (1)(B) of such subsection only if the issuer of such policy or the administrator of such plan discloses to the taxpayer that such policy or plan is intended to be a policy or plan so described.

“(2) DEDUCTION NOT AVAILABLE FOR PAYMENT OF PART B PREMIUMS.—Any amount paid as a premium under part B of title XVIII of the Social Security Act shall not be taken into account under subsection (a).

“(3) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

“(c) SPECIAL RULES.—For purposes of this section—

“(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allow-

1 able to the taxpayer as a deduction under section
2 213(a).

3 “(2) DEDUCTION NOT ALLOWED FOR SELF-EM-
4 PLOYMENT TAX PURPOSES.—The deduction allow-
5 able by reason of this section shall not be taken into
6 account in determining an individual’s net earnings
7 from self-employment (within the meaning of section
8 1402(a)) for purposes of chapter 2.”

9 (b) CONFORMING AMENDMENTS.—

10 (1) Subsection (a) of section 62 of the Internal
11 Revenue Code of 1986 is amended by inserting after
12 paragraph (17) the following:

13 “(18) MEDICARE AND LONG-TERM CARE INSUR-
14 ANCE COSTS OF CERTAIN INDIVIDUALS.—The deduc-
15 tion allowed by section 222.”

16 (2) The table of sections for part VII of sub-
17 chapter B of chapter 1 of such Code is amended by
18 striking the last item and inserting the following:

 “Sec. 222. Premiums for medigap insurance policies and
 Medicare+Choice plans containing outpatient pre-
 scription drug benefits and for long-term care in-
 surance.

 “Sec. 223. Cross reference.”

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 December 31, 1999.

1 **SEC. 3. DETERMINATION OF ANNUAL ACTUARIAL VALUE**
2 **OF DRUG BENEFITS COVERED UNDER A**
3 **MEDICARE+CHOICE PLAN AND A MEDIGAP**
4 **POLICY.**

5 (a) IN GENERAL.—For purposes of subparagraphs
6 (A) and (B) of section 222(a)(1) of the Internal Revenue
7 Code of 1986 (as added by section 2), the Secretary of
8 Health and Human Services shall establish procedures for
9 a Medicare+Choice organization offering a
10 Medicare+Choice plan under part C of title XVIII of the
11 Social Security Act (42 U.S.C. 1395w–21 et seq.) or an
12 issuer of a medicare supplemental policy (as defined in
13 section 1882(g)(1) of such Act (42 U.S.C. 1395ss(g)(1)))
14 to demonstrate that the annual actuarial value of the out-
15 patient prescription drug benefit offered under such plan
16 or policy is equal to or greater than the amount described
17 in section 222(a)(1) of the Internal Revenue Code of 1986
18 that is applicable for the year involved.

19 (b) REQUIREMENTS.—The procedures established
20 pursuant to subsection (a)—

21 (1) shall be based on—

22 (A) a standardized set of utilization and
23 price factors; and

24 (B) a standardized population that is rep-
25 resentative of all medicare enrollees and cal-
26 culated based on projected utilization if all en-

1 rollees have outpatient prescription drug cov-
2 erage;

3 (2) shall apply the same principles and factors
4 in comparing the value of the coverage of different
5 outpatient prescription drug benefit packages; and

6 (3) shall not take into account the method of
7 delivery or means of cost control or utilization used
8 by the organization offering the plan or the issuer
9 of the policy.

10 (c) CONSULTATION.—In establishing the procedures
11 described in subsection (a), the Secretary of Health and
12 Human Services shall consult with an independent actuary
13 who is a member of the American Academy of Actuaries.

14 (d) UPDATE.—The Secretary shall periodically up-
15 date the procedures established under subsection (a).

16 (e) DEMONSTRATION OF ACTUARIAL VALUE.—The
17 actuarial value of the outpatient prescription drug benefit
18 shall be set forth by the Medicare+Choice organization
19 offering the Medicare+Choice plan or the issuer of the
20 medicare supplemental policy in an actuarial report that
21 has been prepared—

22 (1) by an individual who is a member of the
23 American Academy of Actuaries;

24 (2) using generally accepted actuarial prin-
25 ciples; and

1 (3) in conformance with the requirements of
2 subsection (b).

3 **SEC. 4. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**
4 **SURANCE CONTRACTS IN CAFETERIA PLANS**
5 **AND FLEXIBLE SPENDING ARRANGEMENTS.**

6 (a) CAFETERIA PLANS.—Section 125(f) of the Inter-
7 nal Revenue Code of 1986 (defining qualified benefits) is
8 amended by inserting before the period at the end “; ex-
9 cept that such term shall include the payment of pre-
10 miums for any qualified long-term care insurance contract
11 (as defined in section 7702B) to the extent the amount
12 of such payment does not exceed the eligible long-term
13 care premiums (as defined in section 213(d)(10)) for such
14 contract”.

15 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section
16 106 of the Internal Revenue Code of 1986 (relating to
17 contributions by employer to accident and health plans)
18 is amended by striking subsection (c).

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 December 31, 1999.

22 **SEC. 5. AUTHORITY TO PROVIDE FOR ADDITIONAL**
23 **MEDIGAP INSURANCE POLICIES.**

24 (a) IN GENERAL.—

1 (1) EXPANSION OF NUMBER OF BENEFIT PACK-
2 AGES.—Section 1882(p) of the Social Security Act
3 (42 U.S.C. 1395ss(p)) is amended—

4 (A) in paragraph (2)(B), by striking “,
5 and” and inserting “other than the medicare
6 supplemental policies described in subsection
7 (v); and”; and

8 (B) in paragraph (2)(C), by striking the
9 period and inserting “and the policies described
10 in subsection (v).”.

11 (2) AUTHORITY TO PROVIDE FOR ADDITIONAL
12 POLICIES.—Section 1882 of the Social Security Act
13 (42 U.S.C. 1395ss) is amended by adding at the end
14 the following:

15 “(v) AUTHORITY TO PROVIDE FOR ADDITIONAL
16 POLICIES.—

17 “(1) IN GENERAL.—The standards under sub-
18 section (p) may be modified (in the manner de-
19 scribed in paragraph (1)(E) of such subsection (ap-
20 plying paragraph (3)(A) of such subsection as if the
21 reference to ‘this subsection’ were a reference to ‘the
22 Seniors’ Security Act of 2000’)) to establish addi-
23 tional benefit packages consistent with the suc-
24 ceeding provisions of this subsection.

1 “(2) REQUIREMENTS FOR NEW PACKAGES THAT
2 INCLUDE PRESCRIPTION DRUG COVERAGE.—In the
3 case of any benefit package added under paragraph
4 (1) that provides coverage for outpatient prescrip-
5 tion drugs, such benefit package—

6 “(A) shall not provide first-dollar coverage
7 of outpatient prescription drugs;

8 “(B) may provide a stop-loss coverage ben-
9 efit for outpatient prescription drugs that limits
10 the application of any beneficiary cost-sharing
11 during a year after incurring a certain amount
12 of out-of-pocket covered expenditures;

13 “(C) shall not include benefits for prescrip-
14 tion drugs otherwise available under part A or
15 B; and

16 “(D) shall be consistent with the require-
17 ments of this section and applicable law.

18 “(3) USE OF FORMULARIES.—In the case of
19 any benefit package added under paragraph (1) that
20 provides coverage for outpatient prescription drugs,
21 the issuer of any policy containing such a benefit
22 package may use formularies.

23 “(4) SPECIAL OPEN ENROLLMENT.—

24 “(A) ESTABLISHMENT.—If any benefit
25 package is added under paragraph (1), the Sec-

1 retary shall establish an applicable period in
2 which any eligible beneficiary may enroll in any
3 medicare supplemental policy containing such
4 benefit package under the terms described in
5 subparagraph (D).

6 “(B) ELIGIBLE BENEFICIARY DEFINED.—

7 In this paragraph, the term ‘eligible beneficiary’
8 means a beneficiary under this title who is en-
9 rolled in a medicare supplemental policy as of
10 the first day that any benefit package added
11 under paragraph (1) is available in the State in
12 which such beneficiary resides.

13 “(C) APPLICABLE PERIOD DEFINED.—In
14 this paragraph, the term ‘applicable period’
15 means—

16 “(i) in the case of an eligible bene-
17 ficiary who is enrolled in a medicare sup-
18 plemental policy which has a benefit pack-
19 age classified as ‘H’, ‘I’, or ‘J’ under the
20 standards established under subsection
21 (p)(2), the 180-day period that begins on
22 the day described in subparagraph (B);
23 and

24 “(ii) in the case of an eligible bene-
25 ficiary who is enrolled in a medicare sup-

1 plemental policy which has a benefit pack-
2 age classified as 'A' through 'G' under the
3 standards established under subsection
4 (p)(2), the 63-day period that begins on
5 the day described in subparagraph (B).

6 “(D) TERMS DESCRIBED.—The terms de-
7 scribed under this subparagraph are terms
8 which do not—

9 “(i) deny or condition the issuance or
10 effectiveness of a medicare supplemental
11 policy described in subparagraph (A) that
12 is offered and is available for issuance to
13 new enrollees by such issuer;

14 “(ii) discriminate in the pricing of
15 such policy, because of health status,
16 claims experience, receipt of health care, or
17 medical condition; or

18 “(iii) impose an exclusion of benefits
19 based on a preexisting condition under
20 such policy.

21 “(5) ABILITY FOR ISSUER TO CANCEL CERTAIN
22 POLICIES.—Notwithstanding subsection (q)(2), an
23 issuer of a policy containing a benefit package added
24 under paragraph (1) that provides coverage for out-

1 patient prescription drugs may terminate such a pol-
2 icy in a market but only if—

3 “(A) the termination is—

4 “(i) done in accordance with State law
5 in such market; and

6 “(ii) applied uniformly to individuals
7 enrolled under such policy;

8 “(B) the issuer provides notice to each in-
9 dividual enrolled under such policy of such ter-
10 mination at least 90 days prior to the date of
11 the termination of coverage under such policy;
12 and

13 “(C) the issuer offers to each individual
14 enrolled under such policy, for at least 180 days
15 after providing the notice pursuant to subpara-
16 graph (B), the option to purchase all other
17 medicare supplemental policies currently being
18 offered by the issuer under the terms described
19 in paragraph (4)(D).”.

20 (b) SALE OF NON-DUPPLICATIVE MEDIGAP INSUR-
21 ANCE POLICIES AUTHORIZED.—Section 1882(d)(3) of the
22 Social Security Act (42 U.S.C. 1395ss(d)(3)) is
23 amended—

24 (1) in subparagraph (A), by adding at the end
25 the following:

1 “(ix) Nothing in this subparagraph shall be construed
 2 as preventing the sale of more than 1 medicare supple-
 3 mental policy to an individual, provided that the sale is
 4 of a medicare supplemental policy that does not duplicate
 5 any health benefits under a medicare supplemental policy
 6 owned by the individual.”; and

7 (2) in subparagraph (B)—

8 (A) in clause (ii)(I), by inserting “, unless
 9 a second policy is designed to compliment the
 10 coverage under the first policy” before the
 11 comma at the end; and

12 (B) in clause (iii)—

13 (i) in subclause (I), by striking “(II)
 14 and (III)” and inserting “(II), (III), and
 15 (IV)”;

16 (ii) by redesignating subclause (III) as
 17 subclause (IV); and

18 (iii) by inserting after subclause (II)
 19 the following:

20 “(III) If the statement required by clause (i) is ob-
 21 tained and indicates that the individual is enrolled in 1
 22 or more medicare supplemental policies, the sale of an-
 23 other policy is not in violation of clause (i) if such other
 24 policy does not duplicate health benefits under any policy
 25 in which the individual is enrolled.”.

1 (c) NAIC TO CONSULT WITH MEDPAC IN REVISING
2 MODEL STANDARDS.—

3 (1) IN GENERAL.—In revising the model regula-
4 tion under section 1882(v) of the Social Security Act
5 (42 U.S.C. 1395ss(v)) (as added by subsection (a)),
6 the National Association of Insurance Commis-
7 sioners (in this section referred to as the “NAIC”)
8 should—

9 (A) consult with the Medicare Payment
10 Advisory Commission established under section
11 1805 of such Act (42 U.S.C. 1395b–6) (in this
12 subsection referred to as “MedPAC”); and

13 (B) consider the MedPAC report trans-
14 mitted to NAIC in accordance with paragraph
15 (2)(B)(ii).

16 (2) MEDPAC ANALYSIS AND REPORT.—

17 (A) ANALYSIS.—MedPAC shall conduct an
18 analysis of the following issues:

19 (i) The conditions necessary to create
20 a well-functioning, voluntary medicare sup-
21 plemental insurance market that provides
22 coverage for outpatient prescription drugs.

23 (ii) The scope of outpatient prescrip-
24 tion drug coverage for medicare bene-

1 ficiaries, including individuals enrolled in
2 Medicare+Choice plans.

3 (iii) The implications of a medicare
4 supplemental policy that would require
5 issuers of medicare supplemental policies
6 to provide outpatient prescription drug
7 coverage and a stop-loss benefit instead of
8 providing coverage for other benefits avail-
9 able through existing medicare supple-
10 mental policies.

11 (iv) The portion of out-of-pocket
12 spending of medicare beneficiaries on
13 health care expenses attributable to out-
14 patient prescription drugs.

15 (v) The availability of private health
16 insurance policies that cover outpatient
17 prescription drugs to beneficiaries that are
18 not entitled to benefits under the medicare
19 program.

20 (vi) The scope of outpatient prescrip-
21 tion drug coverage provided by employers
22 to medicare beneficiaries.

23 (vii) The impact of outpatient pre-
24 scription drugs on the overall health of
25 medicare beneficiaries.

1 (viii) The effect of providing coverage
2 for outpatient prescription drugs on the
3 amount of funds expended by the medicare
4 program.

5 (ix) Whether modifications of benefit
6 packages of existing medicare supple-
7 mental policies that provide coverage for
8 outpatient prescription drugs or the cre-
9 ation of new benefit packages that provide
10 coverage for outpatient prescription drugs
11 would allow payment for these policies to
12 be integrated with a Federal contribution.

13 (x) Such other issues relating to out-
14 patient prescription drugs that would as-
15 sist Congress in improving the medicare
16 program.

17 (B) REPORT TO CONGRESS.—

18 (i) IN GENERAL.—Not later than
19 June 1, 2000, MedPAC shall submit to
20 Congress a report containing a detailed
21 analysis of the issues described in subpara-
22 graph (A) together with recommendations
23 for such legislation and administrative ac-
24 tions as MedPAC considers appropriate.

1 (ii) TRANSMISSION TO NAIC.—At the
2 same time MedPAC submits the report to
3 Congress under clause (i), MedPAC shall
4 transmit such report to the NAIC.

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